

Treatment of Substance Abuse & Co-Occurring Disorders in Criminal Justice-Involved Persons

CARL FULWILER, MD, PHD

DEPT. OF PSYCHIATRY

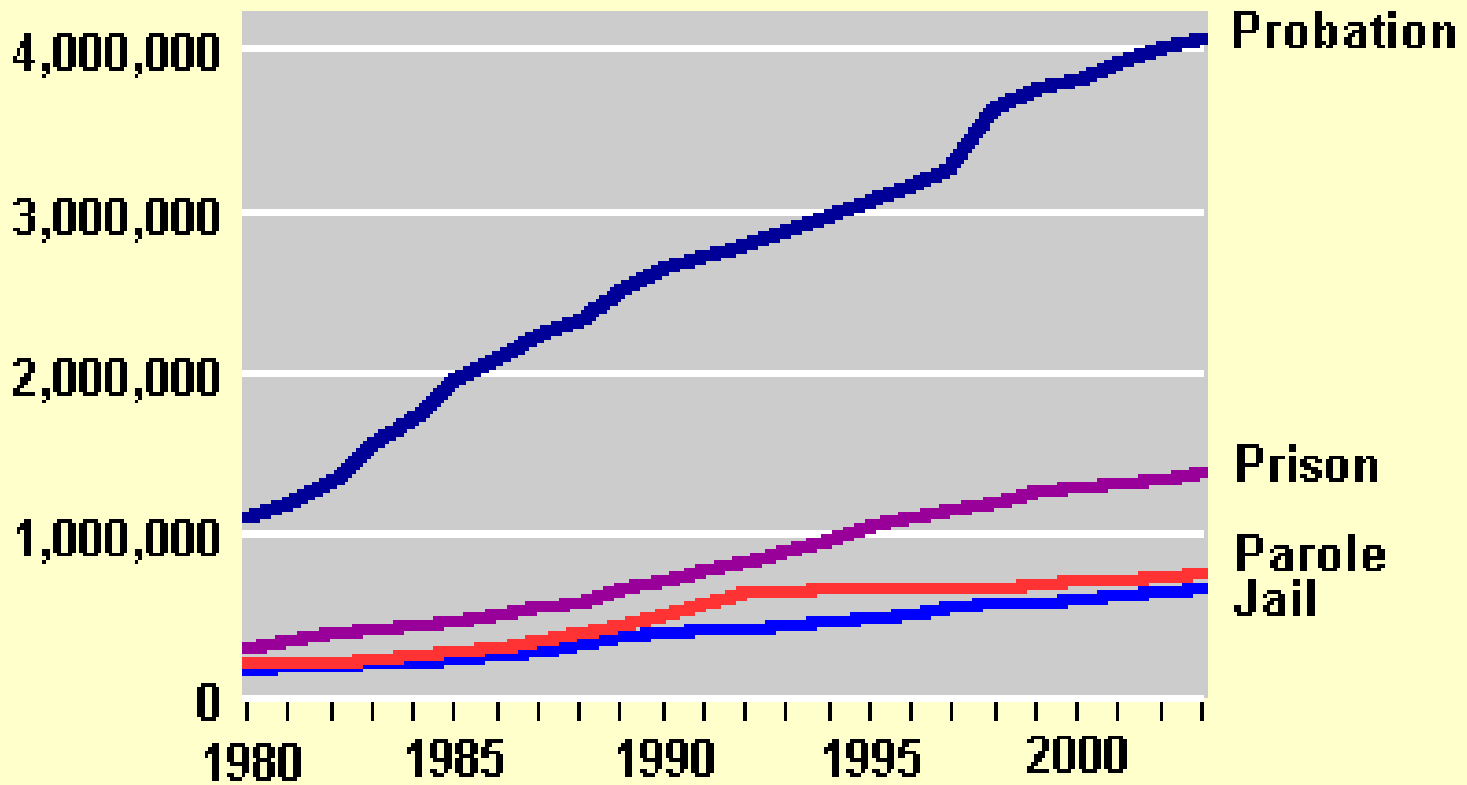
UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL

LEMUEL SHATTUCK HOSPITAL

CARL.FULWILER@UMASSMED.EDU

Nov. 4TH, 2011

Adult correctional populations, 1980-2003



Source: Bureau of Justice Statistics website

Adult correctional populations 2005

- **Approximately 7 million people were under correctional supervision in the U.S.**
 - **Jail: 747,529**
 - **Prison: 1,446,269**
 - **Probation: 4,162,536**
 - **Parole: 784,408**

Criminal justice involvement and addiction

- 65% of adult males who are arrested test positive for recent use of a substance, most commonly marijuana (40%) and cocaine (30%)
- Addiction often involves criminal behavior that patients would never otherwise consider
- Secondary antisocial behavior vs. Antisocial Personality Disorder
- Co-occurring Axis I disorders
- Both have high rates of trauma

Trauma History in Correctional Population

Interview Data (n=978)

	Lifetime	Past 12 Months ¹
Witness of Violence	65.4%	31.7%
Sexual Abuse	55.2%	31.7%
Physical Abuse	90.2%	65.2%
Any Trauma	94.0%	64.7%
Any Abuse	92.9%	61.1%

1 – For Those Respondents Experiencing Trauma in Lifetime

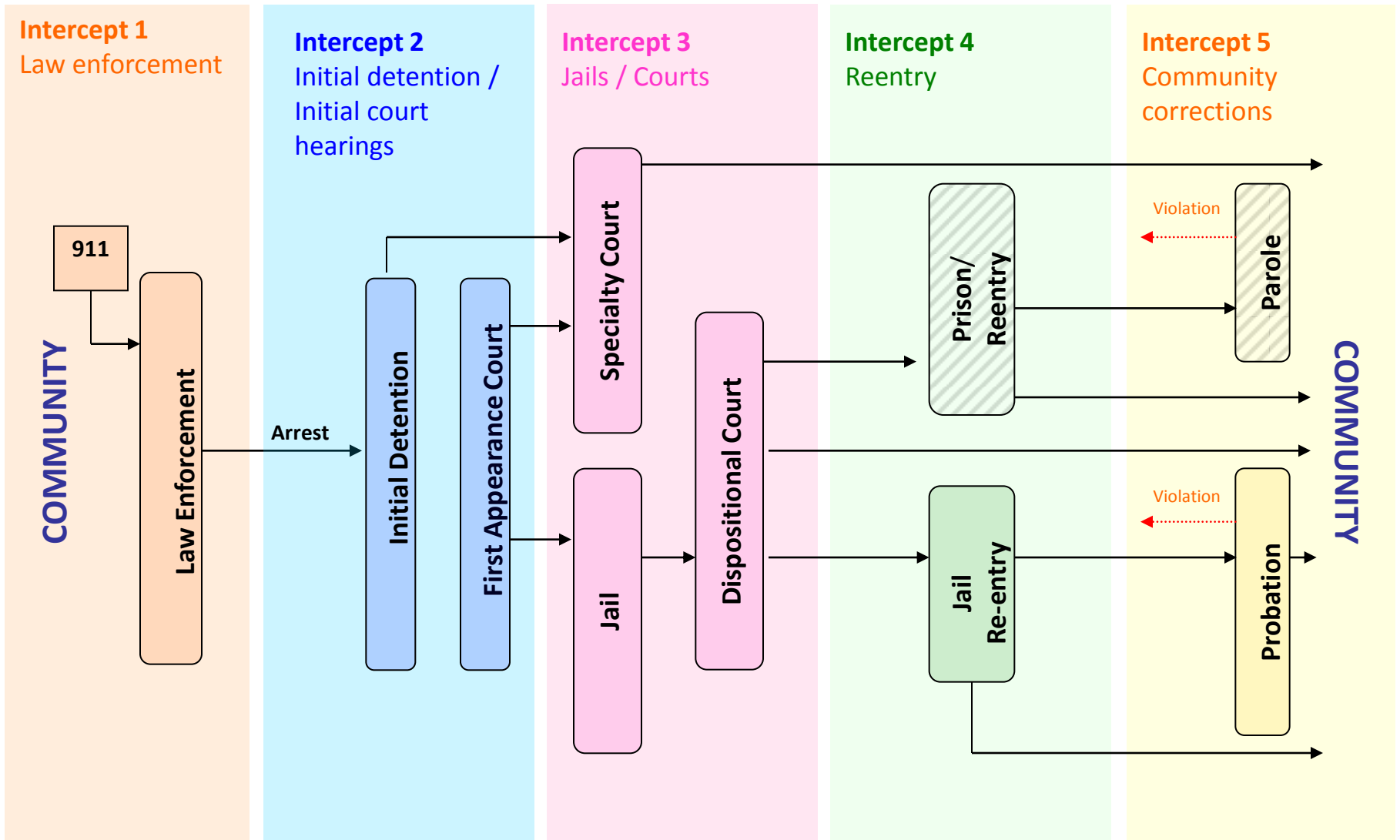
Antisocial Behavior

- In community settings, the majority of criminal and aggressive behavior in substance abuse population is secondary (ASB)
- Antisocial Personality Disorder (ASPD) in substance abuse treatment population is associated with increased risk of re-offending:
 - > 2x as likely to be charged with a crime at 20 yr follow-up (N=1052 admitted to detox or short-term rehab in Sweden (Fridell, 2008: Addictive Behaviors 33:799))

Secondary antisocial behavior vs. ASPD

	ASPD	ASB
Conduct problems in childhood	Yes	No
Substance abuse	Secondary	Primary
Stops with abstinence/recovery	No	Yes
Reduces retention & prognosis	Yes	No
Influences risk	Yes	Less

Intercept points



The drug-court model: Judicial supervision of structured community-based treatment

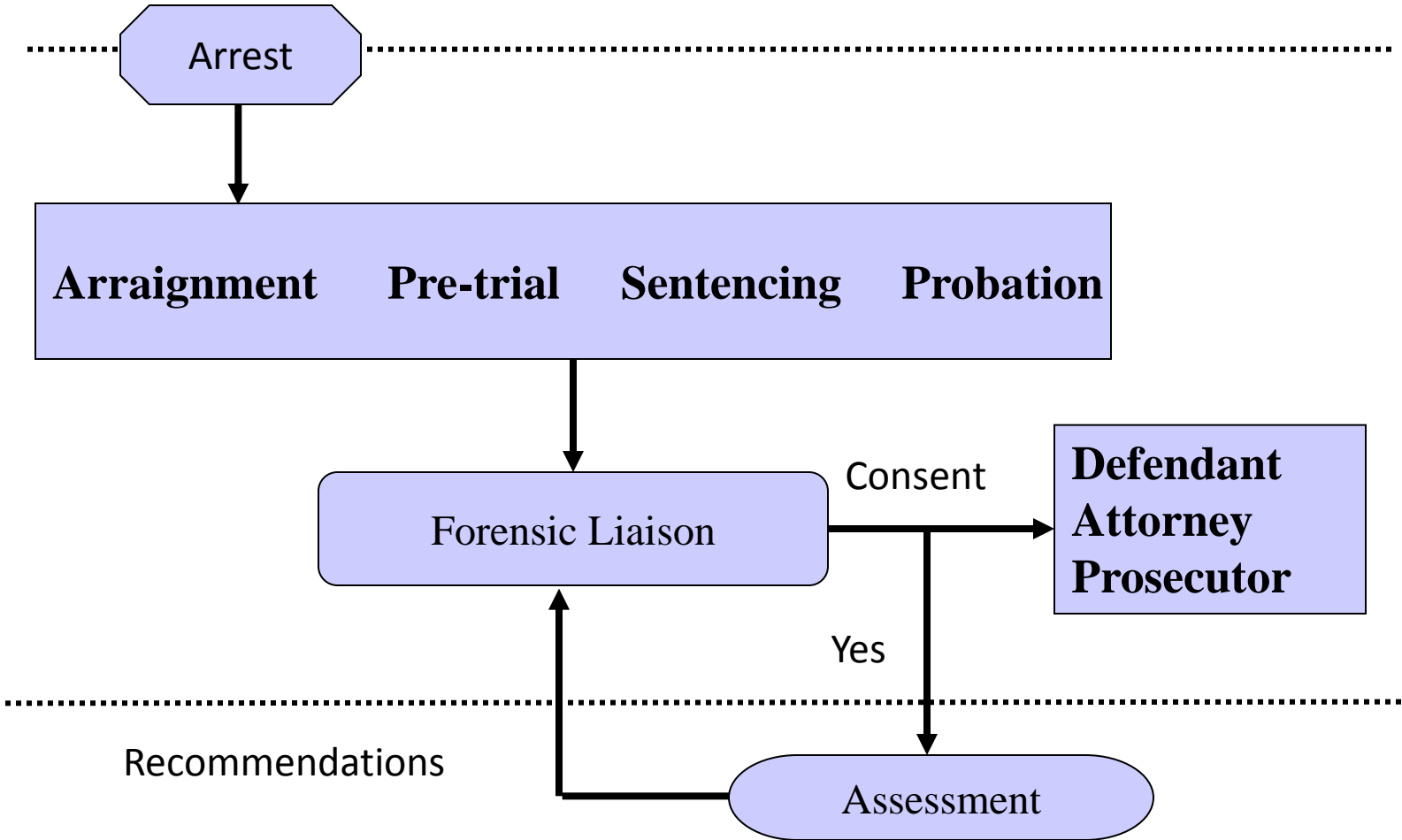
- Timely identification of defendants in need of treatment and referral to treatment as soon as possible after arrest
- Regular status hearings to monitor treatment progress and program compliance
- Increased defendant accountability through a series of graduated sanctions and rewards
- Mandatory periodic drug testing
- Provision of aftercare and support services following treatment to facilitate reentry into the community
- Dismissal of charges or reduction of sentence on successful treatment completion

Forensic Access to Community Services (FACS)

- SAMHSA grant (Fulwiler, PI)
- Tufts/Shattuck Hospital
- Suffolk Co. Sheriff's Dept.
- West Roxbury District Court

Target population

- Axis I mental disorders, including mental disorder with co-occurring substance abuse disorder
- Moderate to severe impairment (GAF \leq 60)
- Capable of informed consent
- Minor offenses; no sex offenses (exclude significant victim injury)



FACS outcomes (N=128)

Mean age 33, males 63%, violence hx 45%

59% entered treatment (most who didn't failed to complete intake process, few ineligible)

16% defaulted or re-arrested, 84% completed probation

About 2/3 remained in treatment after probation

Diversion results (11 sites)

- N = 614 diverted – more females, whites, older than averages for those arrested (but controls matched)
- Interviews baseline 3, 12 mos
- No difference in number of arrests
- Number of days at risk of arrest – diverted had 2 mos more
- Diverted got more meds, more hosp days, more ER use

Maintaining Independence and Sobriety Through Systems Integration, Outreach and Networking—Diversion & Recovery for Traumatized Veterans MISSION – DIRECT VET

SAMHSA grant to DMH (Debra A. Pinals, MD PI)

Co-investigators:

David Smelson, Psy.D., William Fisher, PhD, Carl
Fulwiler, MD, PhD

UMass Medical School

Mary Ellen Foti, MD, DMH

MISSION DIRECT VET SERVICES

- MISSION model with modification to include trauma-informed care
 - All staff to be trained in trauma-informed care
- Defendants/participants to be diverted with services
- Initial, 6 month, and 12 month evaluations
- Process evaluations ongoing

MISSION DIRECT Vet

- Criminal charges with prospect of jail time
- OIF/OEF Veteran Priority
- PTSD or trauma-related condition
- Co-occurring substance abuse and a mental illness

MISSION DIRECT Vet

- Combines 4 evidence-based Practices
 - **Dual Recovery Therapy (DRT)**
 - **Critical Time Intervention Case Management (CTI)**
 - **Peer Support** (Veterans helping Veterans, Role Modeling)
 - **Trauma Informed Care (TIC)**
 - All personnel receive training in TIC
 - PTSD Services
 - **Supported Employment**
 - Employment Training and Job Coaching

MDV Evaluation

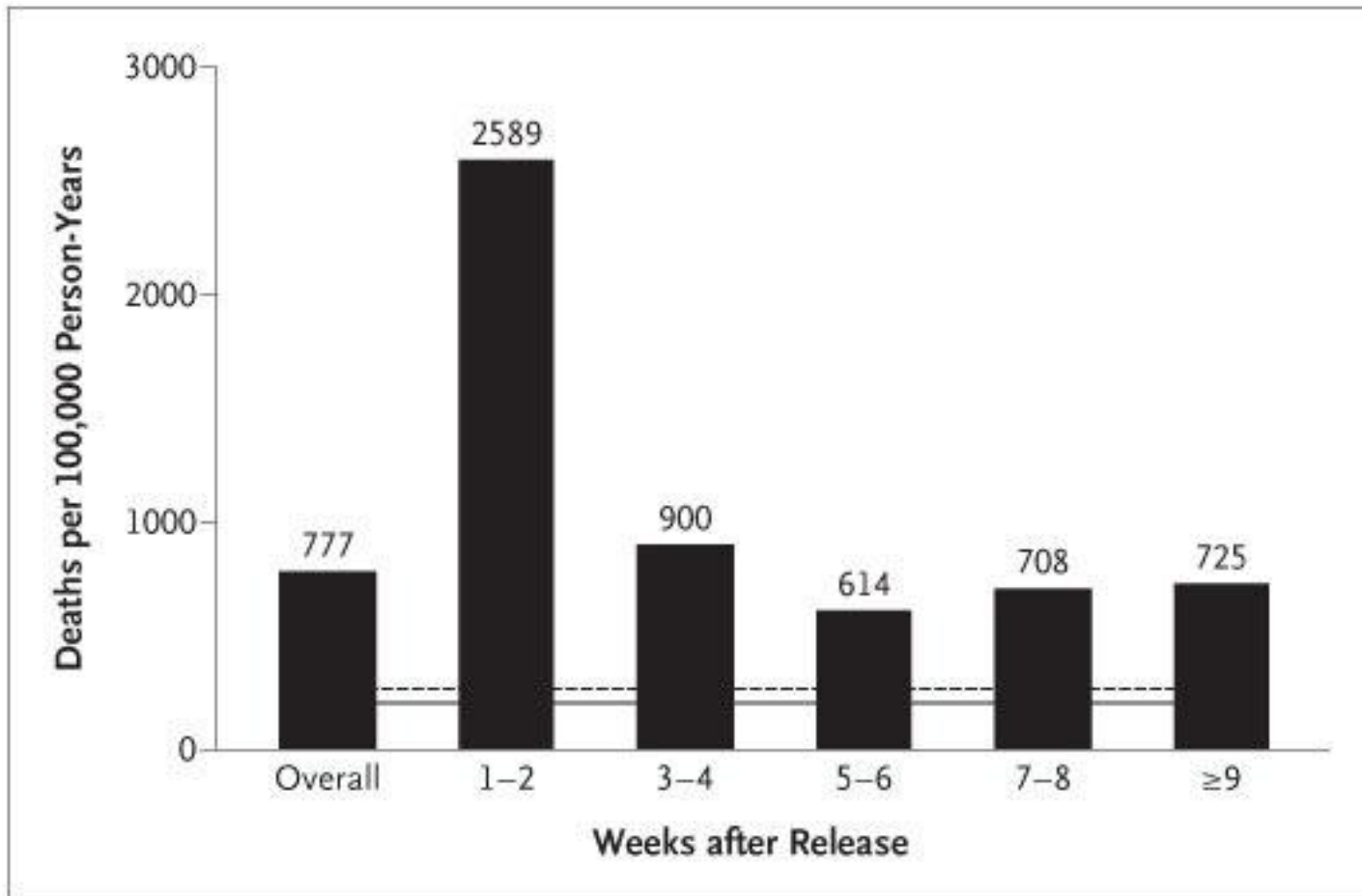
- Assessments

- BASIS-24, ASI, MHSIP, TSR at baseline and 6 and 12-month follow-ups
- Tracking and follow-up assessments to be conducted by UMASS

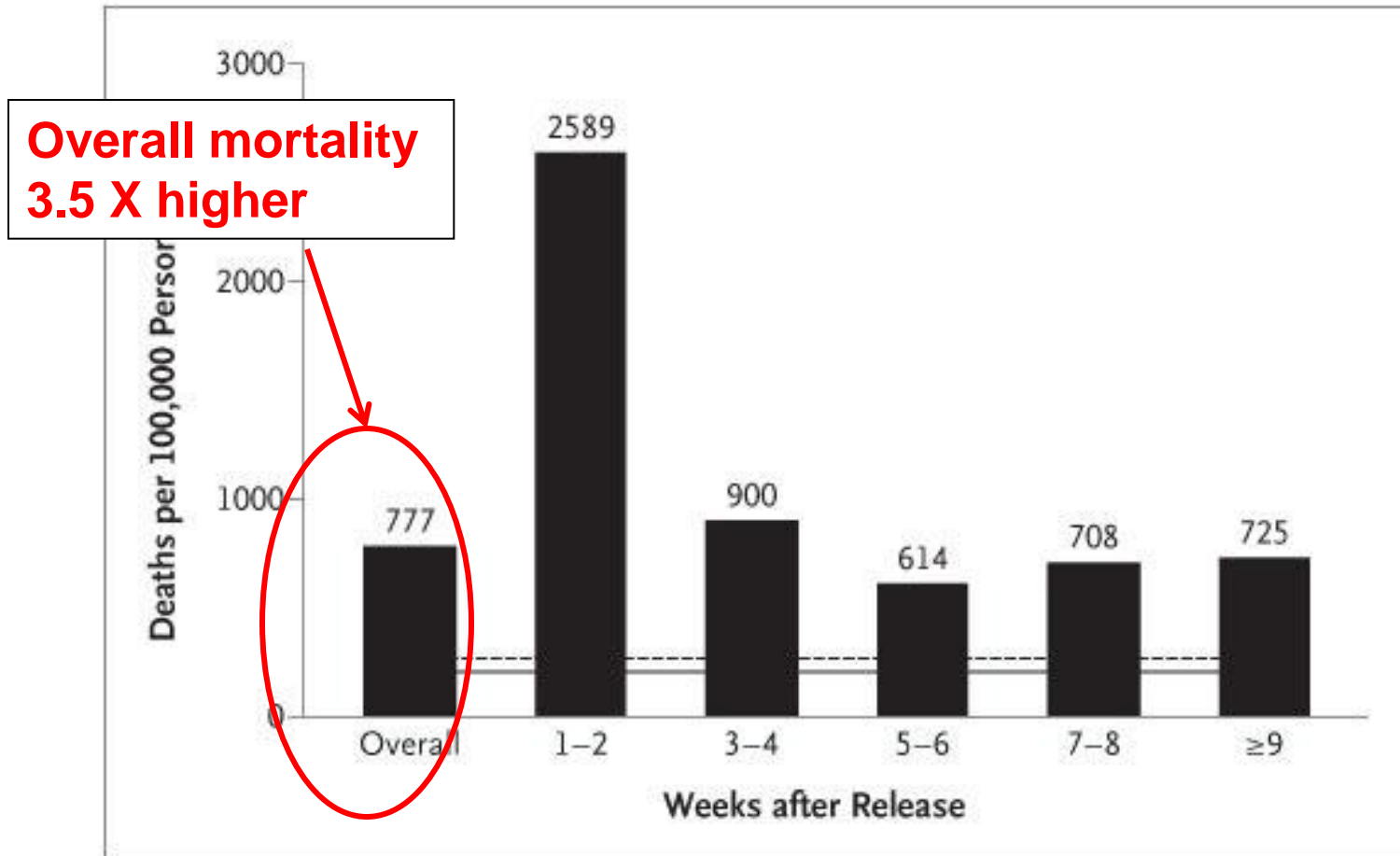
Substance abuse treatment in jail and prison population

	Treatment while incarcerated
Local Jail	7%
State Prison	15
Federal Prison	17

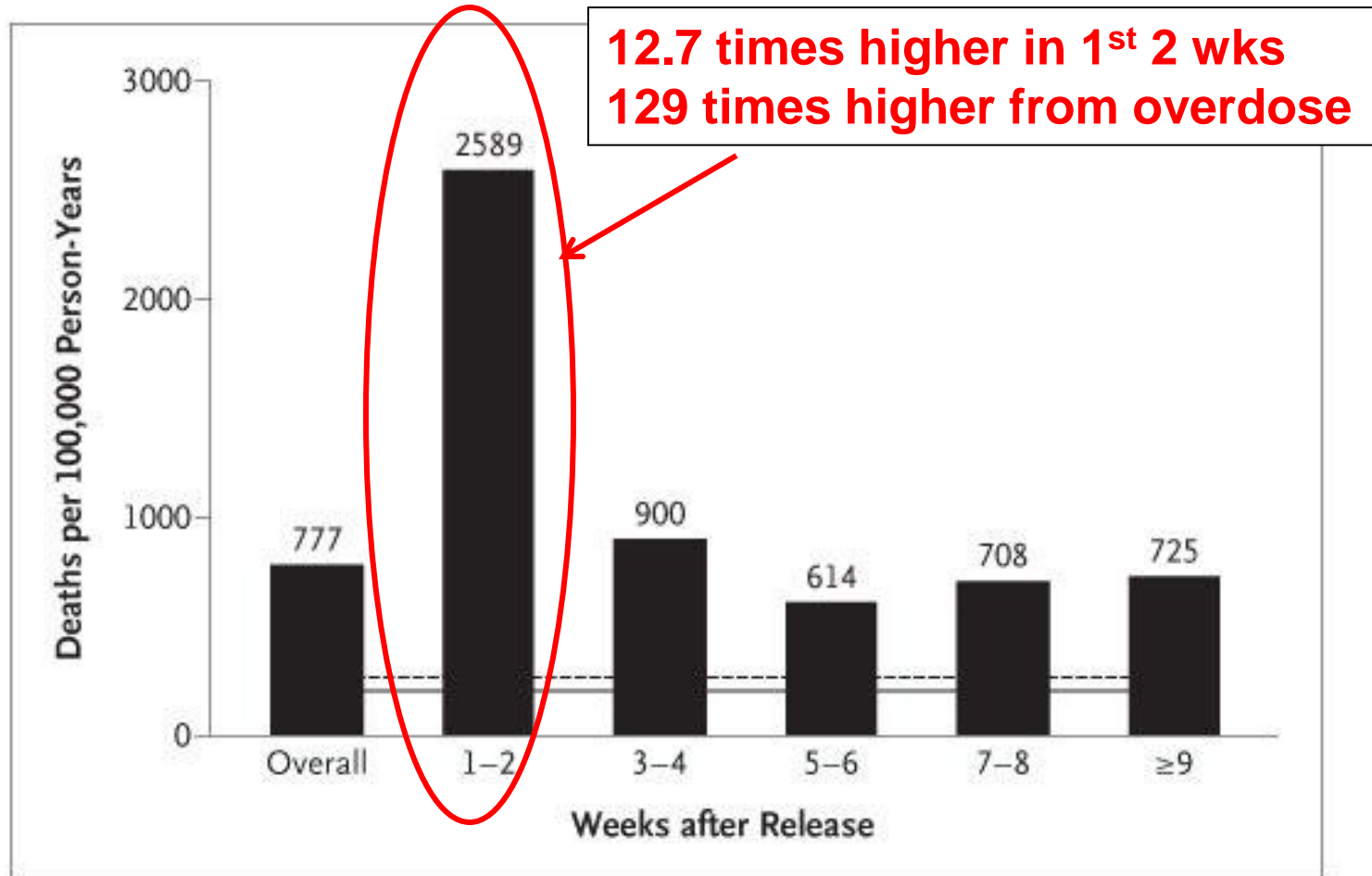
Mortality after release from prison



Mortality after release from prison



Mortality after release from prison



Integration Program: 2-year follow-up

	Criminal Justice	Healthcare Services
Age	39 yrs	39 yrs
Males	92%	55%
Major mental illness	62	79
Other mental illness	29	16
Organic	10	8
Alcohol/drug	95	92

Integration Program: 2-year follow-up

Outcomes

	Criminal Justice N=142	Healthcare Services N=68
Positive (active, transfer, DMH)	45%	72%
Negative		
Not engaged	25	11
incarcerated, drop out	51	13
Relapse	32	28

Predictors of recidivism

- Predictors of incarceration ($p < .05$):
 - ASPD (childhood conduct problems)
 - History of violence
- Non-predictors:
 - Demographics,
 - Type of substance abuse disorder
 - Axis I disorder

MAINTAINING INDEPENDENCE AND SOBRIETY THROUGH SYSTEMS INTEGRATION, OUTREACH, AND NETWORKING: COMMUNITY RE-ENTRY FOR WOMEN (MISSION CREW)

Bureau of Justice Assistance grant
to DMH (Debra Pinals, MD (PI))

In collaboration with:

Department of Correction

Department of Public Health

UMass Medical School

UMass Boston

Community Service Provider – Span, Inc.

Project goals

- Adapt MISSION model to women with PTSD, COD, other psychiatric disorders for re-entry
- Conduct trainings of personnel in trauma informed care and the special needs of this population

Research design

- EXPERIMENTAL GROUP
 - Baseline evaluation (just after release)
 - Mini, BASIS-24, Trauma Scale, ASI
 - COMPAS (from DOC)
 - Follow-up at 6 months (post MISSION-Crew)
- COMPARISON GROUP
 - Receives treatment as usual, without any contact with the research team

Outcomes

- Re-arrest rates one year post-release
- Change in medical, substance abuse, and psychiatric symptoms
- Participants' perceptions and satisfaction with services
- Referral to and completion of services

Trauma scale (baseline)

	Lifetime	Past year
Witness someone seriously injured?	63%	17%
Experience physical violence from non-stranger?	79%	12%
Experience sexual assault from non-stranger?	68%	0%

Principles of treatment

- In community substance abusers, the majority of criminal behavior is secondary
- Trauma is common and requires trauma-informed care
- Risk assessment and management are essential
- Co-occurring mental health disorders are common and integrated treatment is essential
- Coercion is often effective and may be appropriate

Empathy, treatment alliance & trust

- Disrupted early development and attachment processes lead to problems with:
 - Ability to form attachments
 - Emotional regulation
 - Moral reasoning & acceptance of responsibility
 - Criminal thinking

Addressing trauma

- Trauma-informed care
 - Understanding of how trauma impacts development and coping strategies
 - Primary focus on recovery from trauma and wellness
 - Understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery may exacerbate – avoid re-traumatizing
- Trauma-specific interventions
 - Trauma Focused Cognitive Behavioral Therapy
 - Seeking Safety
 - Trauma Recovery and Empowerment Mode

Countertransference

- Isolation of affect
- Therapeutic nihilism
 - Low tolerance for problem behaviors can lead to premature termination and/or undertreatment
- Therapeutic naiveté

Distinguishing ASPD from secondary behavior

Childhood history

- Useful: School history, starting fights, suspensions/expulsions, arrests
- Less useful (specific but not sensitive): setting fires, torturing animals

Interpersonal behavior

- Useful: Lack of remorse, refusal to take responsibility & blaming others, absence of long-term relationships
- Not useful: Manipulation or dishonesty

Treatment implications of ASPD

- Disrupted early development
 - Ability to form attachments
 - Emotional regulation
 - Moral reasoning & acceptance of responsibility
- Criminal thinking
- Attention to risk

Managing risk

- Assessment for ASPD and history of violence
- Monitor risk during treatment and adjust treatment plan if necessary using formalized risk assessment plan
- Coordination with other clinicians and community supports
- Clinical supervision

Criminogenic factors in treatment

- History of antisocial behavior
- Antisocial personality pattern
 - Pleasure seeking, restless, aggressive
- Antisocial cognitions
 - Attitudes supportive of crime
- Antisocial Associates
- Family support
- Leisure Activities
- School/work
- Substance Abuse

Adaptations for criminal justice- involved persons

- Criminogenic factors
- Liaison with CJ agencies
 - Need for structure
 - Supervision
- Outreach services
- Supportive and structured living arrangements
- Family involvement

Adaptations for criminal justice-involved persons

- Problem-solving
 - Moral reasoning
 - Role play
- Cognitive Restructuring
 - Identification of cognitions
 - Cost-benefit analysis
- Interpersonal skills-building
 - Avoiding antisocial peers (“triggers”)
 - Community responsibility
- Engagement challenges
 - Motivational interviewing
 - Stages of change

Coercion

Addicted individuals may benefit because decision-making is impaired and voluntary acceptance of treatment compromised:

- Acquired biological “drive”
- Genetic propensity to progress from abuse to dependence
- Cognitive impairment
- Compromised self-awareness
- Comorbid psychiatric conditions

Forms of coercion

- Judicial process
 - Civil commitment
 - > 1/2 in public treatment programs referred by criminal justice system (drug courts, diversion, probation)
 - Treatment while incarcerated
- Representative payeeship if receiving SSI/SSDI
- Spouse/family

Harm reduction

Many offenders will continue to engage in drug use and high-risk behaviors and professionals will be more effective working with them in reducing their use (and therefore risk) than eliminating it outright altogether (from Marlatt, 2002)

References

- Chandler RK; Fletcher BW; Volkow ND. Treating drug abuse and addiction in the criminal justice system: Improving public health and safety. JAMA 301(2): 183-190, 2009
- Dackis C. O'Brien C. Neurobiology of addiction: treatment and public policy ramifications. Nature Neuroscience. 8(11):1431-6, 2005
- Sullivan MA, et al. Uses of Coercion in Addiction Treatment: Clinical Aspects. American Journal on Addictions 17(1):36-47, 2008.
- Fridell, M., et al. Antisocial personality disorder as a predictor of criminal behaviour in a longitudinal study of a cohort of abusers of several classes of drugs: Relation to type of substance and type of crime. Addictive Behaviors 33:799, 2008
- Gendel, Michael H. Forensic and medical legal issues in addiction psychiatry. Psychiatric Clinics of North America. 27: 611-626, 2004
- Osher, F. Integrated Mental Health/Substance Abuse Response to Justice-Involved Persons with Co-Occurring Disorders,, GAINS Center, 2005 (www.gainscenter.samhsa.gov)
- Wanberg, K. & Milkman, H. Criminal conduct and substance abuse treatment: Strategies for self-improvement and change (2nd ed.). Thousand Oaks, CA: Sage Publications. 2004